

COPING WITH MOM'S BREAST CANCER: IMPACT OF PARENTAL CANCER ON
AFRICAN-AMERICAN ADOLESCENTS

by

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ABSTRACT

Parental breast cancer is an illness that affects the patient as well as the entire family.

A review of literature shows that very limited research exists in the area of parental breast cancer. Research is needed on interactive effects of the patient and family, especially in understanding the experience of African-American families. This report explores theory and family literature to address how clients can be served when facing parental breast cancer. Further research is needed to examine the clinical implications for the clients by enhancing more coping strategies for adolescents and their families who are coping with the diagnosis and treatment of the mom's breast cancer.

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Dedication

I would like to dedicate this paper to my grandfather, Earl White, Sr. I love you and miss you.

CHAPTER 1 - Introduction

The purpose of my research study is to understand more about African-American adolescents' experience of having a mother with breast cancer. I want to focus on how the patient and the family addressed the mother's illness and how it has impacted their family. I believe this to be a significant research topic because of the lack of published research addressing the adolescent's experience. I hope to gain more insight about families' coping with breast cancer and gain more understanding of the adolescent experience during this major life transition.

By having this type of research available, I believe it will help clinicians and other researchers become more knowledgeable and aware of the impact of parental cancer among families and how they can be more helpful in treating families with chronic illness. From my experience of gathering library research, I have noticed that many studies have been conducted on the diagnosed cancer individual, the spouse, and the family of the cancer victim but the impact of parental cancer on the patient's adolescent is limited. In addition, there is also a huge limitation in understanding the parental cancer of minority families. Because of this gap in research, I would like to change the way this research topic has been studied. As a marriage and family therapy intern, I have grown to appreciate the diversity among clients and to gain a better understanding of their cultural beliefs and family functioning. In the field of chronic illness and therapy, I feel that this type of research will provide researchers with more direction for future research and application of knowledge, when working with diverse families with chronic illness. It

also gives researchers in this area of interest unique case example. This can be valuable in understanding specific cases and situations with clients and their experiences as a whole.

Implications for a quality research project can provide information for not only marriage and family professionals but other mental health professionals as well. In addition to that, physicians, nurses, or other health care professionals would find information from the study intriguing and would possibly offer them more insight or a greater understanding of the experience of the breast cancer patient and her adolescents. In essence, it will offer more understanding in how health care professionals' involvement is important when helping patients and their families. Professionally and personally, I am sure that professionals might recognize themes with various patients and their families. Because of those experiences, I hope that, as therapists, health care professionals, family members, or even patients, the report will give life to the meaning and richness of the topic. The researcher hopes that the topic will help us as professionals to gain understanding, respect, and care for families who are experiencing this chronic illness.

Reviewing empirical literature, I would like to address the impact of parental breast cancer on the adolescent. From my experience gathering research, I have noticed that many studies focus solely on the individual patient or the couple dyad and have not really considered the children in the home. Other studies have focused primarily on the perspective of parents or the mother-child relationship, but not the child alone. Because of this lack of research, I have found it a challenge to find relevant literature that addresses the interactive effects of the patient and family, especially understanding the experience of African-American families. I will address, in more detail, the literature on

the coping strategies for breast cancer patients and the sources of social support that have been identified. I did discover, through analysis of relevant literature, that the impact of parental cancer on the adolescents has common themes. The themes were emotional and behavioral changes, different perceptions and knowledge of parent's cancer, changes in roles within the family, and different ways of coping.

Personally and professionally, I have become interested in this study because of the gap in literature. I would contribute to the research by addressing this limited population and understanding more about those common themes found in literature surrounding this phenomenon. Personally and professionally, I have experienced the process of a loved one and a client, both of whom are going through journey of having cancer. From both experiences, I have gathered so much but would still like to understand more, not just from my own experience as a grandchild of a cancer patient but also through the experience of actual children of patients. I would love to examine more about cultural differences in coping strategies, as well as social support. My question is how does the patient addresses the illness she has with her adolescent and what can we as professionals learn from that experience to help others when dealing with this type of client profile. How does an African-American mother, who is naturally the caregiver in the family, deal with that role change and how does it affect the family functioning, especially the adolescent's ability to cope?

Of course, I have considered the limitations of choosing this topic for my master's report. I am not actually collecting and data and gaining actual accounts of the experience of the adolescent. On the other hand, I have an opportunity, in the near future, to expand or even change perspectives when I continue on with my doctorate work. I am open to

looking at the topic from different perspectives and I would love to gain more insight by interviewing families and adolescents about their experience. I feel the report will capture the some of the gap in current literature in this growing area. Limitations I do foresee are the limited number of research articles in my specific topical area. In addition to that, I feel that I am limited because I am not collecting data from participants.

CHAPTER 2 - Review of Literature

Research has addressed the impact of the diagnosis of cancer on individuals, their significant other, and their families (Chalmers, Thompson, & Degner, 1996; Compas, Worsham, Epping-Jordan, Grant, Mireault, et al., 1994; Walsh, Manuel, & Avis, 2005). Limited research has been conducted on the impact of the cancer diagnosis on the patients' children. According to the American Cancer Society, in 2006 an estimated 1,399,790 males and females in the United States were diagnosed with cancer. An estimated 5% of these were diagnosed in their child-rearing years. Breast cancer has become relatively more common among women, especially during childbearing age. According to Bloom & Kessler, 1 in 9 women in the western world develop breast cancer and more than a quarter of those women do so while having children living in their homes (1994). According to recent statistics, the Centers for Disease Control and Prevention reported that 186, 772 women were diagnosed with breast cancer in 1999-2004 from the cancer incidence and mortality data (2004).

Breast cancer is the most common form of cancer in women. Breast cancer is unique among other types of cancer because of its visible changes in the woman's body image. These changes can affect the woman's feelings of attractiveness, especially when any type of reconstructive surgeries is part of the woman's breast cancer treatment. The impact of physical and sexual functioning is another change a woman might face with having breast cancer. Even as a mother, the woman's breast cancer might also impact her emotional, social, or role function as a caregiver in the family, due to the impact of her cancer. Parental illness is not limited specifically to cancer but it does not take away from the uniqueness of breast cancer. Research has demonstrated that parental illness,

like breast cancer, can affect the family, often resulting in an increased conflict and possible disruption to daily routine and availability of parents to their children (Davey, Gulish, Askey, Godette, & Childs, 2005). The findings indicated that the adolescents' lives became complicated due to their mother's illness. Adolescents from the pilot study reported that they often felt burdened with new roles and responsibilities. Because of those changes, participants felt distressed, sad, worried, and fearful during their mother's diagnosis and treatment. It was suggested by the adolescents that resources to promote more family understanding and communication between parents and adolescents would have been helpful to them. Most studies make the assumption that the diagnosis of cancer has been shared in the family. It is important for the reader to understand that mother's diagnosis may not be "out" in the family. Families may attach great meaning to the act of informing the rest of the family about the breast cancer diagnosis. How this is carried out and the messages that are conveyed to the children by the parents is of paramount importance in how the children will receive the message and react to their mother's breast cancer. From an anthropological stance, it is important to understand that families vary in their pacing of communicating openly about a cancer diagnosis and not assuming that all families have addressed such a vital part of the mother's illness.

According to Grabiak, Bender, & Puskar, a parent's cancer diagnosis can result in behavioral, emotional, and physical problems, as well as decreases in family functioning (2007). In this analysis of literature, the researchers reviewed and analyzed book chapters, descriptive studies and intervention studies to gain the four major themes of the adolescent's experience of paternal cancer. These themes were organized around emotions, behaviors, changes in roles, and ways of coping. Behavioral problems can

range from internalizing to externalizing behaviors. Adolescents could display those behaviors by internalizing behaviors through emotions such as depression or anxiety. Externalizing behaviors could be display through aggression or disruptive behaviors at school or home. Those particular changes can impact the adolescent's behavioral, emotional, and physical functioning, as well as their academic performance. Family functioning is affected through family communication, family involvement, and just general family functioning. Adolescents experience problems in those areas with their family members because of the adolescent's emotional or behavioral problems that are not addressed between the parents and adolescent because of these negative changes. A qualitative study conducted by Forrest, Plumb, Ziebland, & Stein (2006) found that parents can underestimate children's emotional and behavioral difficulties due to the parent's illness. The qualitative study consisted of interviewing thirty-one children over the age of nine. The children's parents signed an informed consent and the children were interviewed at their homes, without their parents present, by an experienced child psychiatrist for an hour-long, semi-structured interview about their experience of their mother's illness. From the interviews, the researchers reported that parents sometimes misunderstood their children's reaction and underestimated the emotional impact or did not recognize the children's need for more communication and information about the illness and its treatment. Often parents found this time to be a stressful time for them, as they tried to prevent traumatic events that might produce longer consequences for their children. Parent reported that they found it a challenge of coping with their cancer and treatment. They also faced the challenge of wanting to meet their children's needs which can be challenging for families.

A focus group, conducted by Davey, Gulish, Askew, Godette, & Childs (2005), found that adolescents' lives had become complicated by their mother's breast cancer. The study consists of three focus groups with Caucasian and African-American adolescents, who have a mother being treated for breast cancer within the last two years. The participants were five female and five male adolescents (4 Caucasian and 6 African American) who were recruited by a referral services at the Wellness Community in Atlanta, Georgia and Athens Regional Hospital in Athens, Georgia.

Researchers reported that the adolescents often felt burdened by additional roles and responsibilities they had to perform, because of their mother's illness. In general, adolescents are dealing with their own development and might not be able to process the implications of breast cancer and the demands of additional roles and responsibilities. Adolescents are at different developmental stages and might not be old enough to comprehend the implications of breast cancer and the increased demands of adult responsibilities. Typically, adolescents were forming their own identities and beginning the process of separation from their families. Having such a life changing event can become overwhelming for an adolescent in such a molten state. Christ, Siegel, & Sperber conducted a qualitative study with a sample of 120 adolescents between the ages of 11-17, who were selected at Memorial Sloan-Kettering Cancer Center in New York City. The adolescents were interviewed for about ninety minutes with the consent of their parents. The researchers reported that adolescents are usually torn between the normative tasks of their adolescent group and dealing with the practical, psychological, and social tasks demanded by the illness (1994). The mother's prognosis for survival has to be considered in understanding loss of a significant aspect of personal functioning, a

possible damage to physical appearance, or even the loss of physical functioning. Because of the change in mother's role in the family, there is a high possibility that the father or even the children have to assume more responsibilities in the family. The mother's prognosis can bring challenges in how the adolescent chooses to deal with taking time to develop his or her own practical, psychological, or social tasks and forming relationships outside of the family. The worse the prognosis is for the mother's survival, the more detrimental will be the effect on the adolescent. This is most often true for the oldest child in the family (Armdsen & Lewis, 1994). Older children find it more of a challenge because of their responsibilities to their younger siblings. Being older carries more responsibilities because he or she is the oldest child in the family. Compas, Worsham, Epping-Jordan, Grant, Mirealt, Howell & Malcarne(1994) reported that, including all age groups, adolescents have the highest levels of stress/anxiety and specifically. Participants for this qualitative study were selected through the Vermont Cancer Center, University of Vermont. Each of family members participated in the one to two hour interviews. Adolescents, of the 35 women who were diagnosed with breast cancer, participated in this study varying the between the median age of seven to twenty-two years of age. Adolescent females, whose mothers have been diagnosed with breast cancer, were the most significantly distressed. Researchers reported that the stress-response and anxiety/depression symptoms varied among children, depending on age, sex of child, and sex of ill parent. Developmentally, there are differences in an adolescent's response to stress associated with severe illness in a parent, with younger children being more likely to display symptoms. Adolescent girls may be especially vulnerable to the presence of a severe disease in a parent because adolescents are more cognitively aware

of the illness, than younger children, as a stressor for his or her parent with cancer and for the entire family.

Adolescent Gender Differences

Research has suggested that, among adolescents whose mothers have breast cancer, there are gender differences in the ways that females and males cope with the illness. The Northhouse study consists of 189 patient/family member dyads of the mother having a reoccurrence of breast cancer and the adjustment of family members. The adolescents were identified as the family caregiver and were selected from four oncology center and satellite oncology clinics in the Midwest area. Northhouse, Crachiolo-Caraway, & Appel reported that adolescent females want to support their mother during the course of illness. Although these adolescents are beginning to individuate from their families, they still recognize their love for their mother and the debt that they owe her for raising them. The daughters also reported feelings of anger and resentment. They might even withdraw from their mothers (1991). Of course, the daughter might fear that they might be at risk of inheriting their mother's disease. Therefore, resentment towards their mother is present because of the possibility of their contributing the daughter's genetic vulnerability to cancer. Therefore, these teenage women are faced with the paradoxical situation of increasing their care for their ill mother while, at the same time, feeling resentment towards their mother for contributing to their physical propensity for cancer. Compas et al. found that older daughters of women who had cancer were more likely to experience symptoms of distress, compared with sons of women and daughters of men who were ill (1994). Young women tend to find it more distressing because of the emotionally focused connection between mother

and daughter and because of the shared experience of coping with mother's illness. An exploratory study by Brown, Fuemmler, Anderson, Jamieson, Simonian, Hall, and Brescia (2007) examined the adjustment of children with active and nonactive breast cancer. The participants of this study consist of 40 women with breast cancer and their oldest child, who were at least 8 years of age. Patients were identified from a list obtained from a cancer center's database of eligible patients from a middle-city in the southeastern part of the United States. Researchers found few differences between the active and nonactive breast cancer groups. Until that study, most research reported that daughters of mothers with breast cancer would have higher depressive symptoms. They did note that children of a mother, who had support of friends and family, had fewer depressive symptoms. These findings support the significance between amount of social support and psychological adaptation among individuals with chronic illness. Women reported that the support of caregivers was associated with better psychological adjustment among their children which indicated that social support is important among individuals with chronic illness and their families.

On the other hand, sons also have had difficulties adjusting to mother's breast cancer. According to Northouse, Crachiolo-Caraway, and Appel (1991), adolescent males have the tendency of avoiding communication that directly addresses his mother's illness. Males had a tendency to use coping techniques which included avoiding stressors to keep a sense of normalcy, rather than actively addressing their mothers' having cancer. They also would prefer not to share information about the illness outside his family, in order to avoid additional stress by avoiding talking about their problems outside the home. Typically, adolescent sons acted out in behavioral ways, such as rebellion and

rule-breaking, rather than to openly communicate their emotions. Males have a tendency to use more active problem-focused strategies when dealing with stressors, such as distracting attention away from their mother's illness by acting in problematic ways. It is quite obvious that there are gendered ways of coping with stressors in this case, mother's illness.

Adolescent Racial Differences

Coping strategies differ with race as well as gender. Current research on adolescents and parental cancer has specifically focused on the population of middle-class Caucasians. Ethnic minority groups have been limited in these studies. According to Slavin, Rainer, McCreary, and Gowda (1991), African-American adolescents are possibly taught by their family to learn and rely on family first and extended family second for support. Research in this area of racial differences report how different adolescents cope with stress and the importance of social support in their lives, often referred to as the "buffering hypothesis" (Cohen & Willis, 1985). The model suggests that strong support from family, clergy, and even the church community helps African-American adolescents cope in stressful environments. According to Maton, Teti, Corns, Viera-Baker, Lavine, Gouze, & Keating (1996), "racial difference in the use of coping strategies of spiritual and family support, with the propensity for African-American adolescents to use strategies of support more frequently than Caucasian adolescents did" (p. 565). African-American families tended to rely more on their faith and church community as a way of coping and gaining strength as a family, in part, because other coping resources were closed to them because of a history of racial prejudice. It is important to address more coping skills of different racial and ethnic backgrounds because

of such limited research in area of parental cancer and minority adolescent. A pilot study conducted by Davey et al.(2005) reported that, when adolescents were asked about how the adolescents coped/handled their mother's breast cancer and treatment, there were differences by race. Adolescent Caucasian and African-American males seemed less expressive, when asked about their feelings and how they coped. The adolescent males seemed more introspective and withdrawn and relied more on distraction with keeping busy, especially with athletics, than adolescent females. Davey et al. (2005) found that a male, African American report that [When I got worried, I try to take my mind off it, like, play basketball or something like that....just hang out with my friends] (p. 253). There were many similarities in the reactions of male adolescents, regardless of whether they were Caucasian or African American.

Adolescent females reported more differences in their ways of coping, in regards to race. African-American females were similar to males in the way they handled their mother's illness. "For example, they tended to keep going with their normal routines as much as possible, tried not to think about it, and were less expressive about their feelings during the interviews." (p. 254). A quote from an African-American female stated that "I tried to go about my life as normal as possible...because if I tried not to think about it, then it would eventually go away."(p.254). On the contrary, White Caucasian females reported sharing feelings more with others, writing, and using different mediums of expression to cope with mother's illness. Perhaps these differences have to do with the differences in the interpersonal expression of feelings between female members of the dominant culture versus females from a culture which is not dominant. Religious faith was found to be different among the adolescents. African-American females and males

attended church more often and prayed daily to cope. For example, an African-American girl stated, “I go to church usually every Sunday with my mom unless mom is not feeling well...I find it helpful and I pray at least twice a day for my mom.” (p.254). The church has always played a pivotal role in the lives of African-American people, especially in the times of trouble. The study provided excellent descriptive quotes in understanding more about the experiences of the adolescents. Adolescents from this study shared that it would be important to encourage others, who are dealing with parental illness, to offer more support of coping with illness by improving communication and understanding among family members. Adolescents also expressed that the openness to express their fears and feelings to parents, the support of their family members, and even their school can be effective when helping other teens and their families when they are dealing with parental illness.

Limitations

A search for published studies and literature reviews on the impact of parental breast cancer on the adolescent was conducted on PubMed, MEDLINE, and PsycINFO. The vast majority of the research articles that were found were biomedical and not psychosocial in nature. I covered the content of the psychosocial research articles on parental breast cancer in the literature review. However, few studies were quantitative and most studies offered small sample sizes and limited diversity among participants. It is important for the reader to understand that these limited research studies make it difficult to draw any specific conclusions from this body of literature, in order to generalize to families dealing with parental breast cancer. Generalizations from the studies should be addressed with caution and do not necessarily fit for all families, for

two reasons: 1). such limited research on the specific topic, as well as 2). the uniqueness of each family.

Clinical Relevance

Research does highlight the importance of gender and racial differences and styles of coping but it is quite limited in providing clinical interventions with a specific minority population of adolescents and their families. Clinical attention is needed because of the limited intervention literature in the area of parental cancer and adolescents.

Providing and teaching individuals about coping skills that are sensitive to females and males of different ethnic and racial backgrounds is a must. Offering literature in this area will not only benefit us as clinicians but other support persons an adolescent might need.

Adolescents develop differently from early, middle, to late adolescence, and having studies to address those different would be informative, if such studies existed.

Addressing cultural, socioeconomic, racial, and ethnic diversity within literature will also expand upon that limited research. It will offer support to the importance and ideas about adjustments in how the role of health care professionals' involvement, which is so important when helping patients and their families. The report could not only contribute to erasing the gap in literature but also informing and guiding researchers to address even more inquiry for future studies. It is just important that marriage and family therapist continue to study more about families and adolescents to understand more about adjustment, coping, and communication among families and parental breast cancer.

CHAPTER 3 - Relevant Theory of Parental Cancer

Studies of the impact of parental cancer on the adolescent have mainly consisted of quantitative, mixed methods, and qualitative studies (Nelson, Sloper, Charlton, & While, 1994; Grant & Compass, 1995; Lewis & Hammond, 1996; Spira & Kenemore, 2000; Harris & Zakowski, 2003). The researchers have focused mainly on a systems framework approach to the families' dealing with chronic illness within the family. Therefore, researchers have used the assumptions from a systems perspective that the system is interconnected, the system can only be understood as a whole, and a system is affected by its environment.

According to family systems theory, (Bowen, 1978), the condition of one family member influences the other family members. Systems theory also states that subsystems, such as marital, parental, parent-child, and sibling interact with one another, as well as influence each other. Therefore, this systematic interaction determines the level of psychosocial functioning and well-being of the family (Veatch, 1999). So when a parent is diagnosed with cancer, all family members are affected by the illness.

From a family systems perspective, the stress of the illness affects the balance or equilibrium of the system, which may lead to disturbance in the system. Johnston, Martin, Martin, and Gumaer (1992) suggested that, in cases as such this, there is a strong likelihood of the role reversal of the "sick" parent. The "sick" parent may become the child, often the youngest child in the family, and the child may become the "parent." In these circumstances, the developmental tasks are often compromised. A child or adolescent is forced to become an adult, thereby losing his or her childhood. Therefore,

the child may become overwhelmed, emotionally distressed, and is forced to deal with feelings of stress, fear, guilt, depression, and anxiety (Miller, Wilcox, & Soper, 1985).

Similar to family systems theory, the family systems-illness model defined by Rolland to provide a normative systems model for families dealing with illness and disabilities (1994). Rolland's model highlighted the processes of between the psychosocial demands of various chronic disorders and how time plays a key role in family functioning. Rolland (1994) found the following:

The model offers a useful systemic view of family adaptation to serious illness in a child or an adult as a developmental process over time. Considering the family the unit of care, in which a broad range of family forms and biopsychosocial interactions are normative, enables us to develop a model that takes as its central reference point the idea of goodness of fit between a family's style, with its particular strengths and vulnerabilities, and the psychosocial demands of different disorder over time. (p.12).

Rolland also addressed parental illness, based upon addressing areas of communication and roles. Themes of anxiety may be developed when open communication is not established among children and parents. He also addressed role changes and how families cope with conditions by creating definitions of any changes or flexibilities in their current roles in areas of caregiving, as well as child-rearing responsibilities. Gaining a clear understanding of the psychosocial demands over time offers the family realistic needs that might include changes in family responsibilities and helping with caregiving. The key here is that, when role shifts occurred, are they sensitive to the adolescent's development.

As you can see, theory began with a systems theory approach and has expanded further with an illness model, as well as some aspects of family life development. Boss (1988) stated that families can be organized as units that demonstrate symptoms of stress. She defines family stress “as a disturbance in the organization and process of family life.” (p. 32). In essence, an individual’s perception of stressors is guided by his or her understanding of time and sequence of the family developmental norms. For example, this can explain more about the levels of stress for the adolescent and the family and how each family member is coping with the mother’s illness. It offers more insight into the different perspectives of families and how specific populations deal with family illness.

A few intervention studies and qualitative studies used more of a social constructionism approach (Davey et al., 2005; Lewis, Casey, Brandt, Shands & Zahlis, 2005; Taylor-Brown, Acheson, & Farber, 1993). Social constructionism focuses on the interactions of understanding meaning making among people. People construct their social environment by trying to make sense or meaning to the events in their lives. An adolescent, who believes that his or her mother’s cancer is a “punishment from God,” will react quite differently to mother’s cancer than one who believes that his or her mother’s cancer is caused by a medical predisposition to cancer. The approach uses those meanings to open up new constructions for the presenting problem for a specific family. It became a shift in perspective from only a systems approach to a theory which focuses on subjective interpretations of reality, opening up a greater understanding of the systems’ meaning of a phenomenon. Those combined approaches offered readers themes about the effects of parental cancer on the adolescent and provided information regarding shared concerns and additional coping strategies. The qualitative studies focused more on

the adolescents and gave them an opportunity to share with researchers their feelings of being angry or guilty. These appeared to be normal feelings of other adolescents in similar circumstances. These studies emphasized communication and the importance of gaining more understanding of the adolescent's experience, as well as the parents' concerns.

For my report, I plan to organize my thinking around a family system approach but I am more interesting in the family process. Theory about family process can be used in a more applied way of studying families and I am interested in expanding upon that framework. In addition, I would like to focus more on a social constructionism view of the adolescent and his/her interpretation of parental breast cancer. From the theory and research in the area of parental cancer and adolescents, common themes have emerged that encourage adolescents to have more opportunities to openly express and communicate aspects of their parent's illness and their personal development during this time.

As a therapist, I work from both solution-focused (SFT) and narrative therapy approaches. Solution-focused therapy was developed by Steve de Shazer and Insoo Kim Berg (de Shazer, 1988; Berg, 1994). This type of therapy was based upon helping clients find solutions, rather than focusing entirely on solving problems. The goal is to find solutions, based upon exceptions when things are going well for the clients. It also challenges the client to focus on times when exceptions were present, in order to discover solutions that clients may have forgotten or had not noticed, in order to build upon those solutions (O'Hanlon & Weiner-Davis, 2003). In helping clients with their salient goals, SFT utilizes the "miracle" question. The question can be asked in this way: "Suppose you

were to go to bed tonight, when you awake in the morning, a miracle has occurred and your problem was solved. What would be different? How would you know?" (de Shazer, 1988). In this manner, the therapist can help the client create a goal for his or her own therapy. Subsequently, the client can keep his or her focus on the goal, rather than being stuck, obsessing about his or her problems. As the therapist, the ideal goal of this technique is to encourage the client to move towards a satisfactory future.

Scaling questions are also techniques used in SFT therapy. They may be used to as a therapeutic tool. The therapist can ask the client to rate, on a one-to-ten scale, the clients' situation prior to coming to therapy and then asking the client to rate their last week on the same scale. Clients are asked where they would rate themselves in order to feel more satisfied. The final scaling questions provide the clients with the opportunity to recognize that things do not have to be perfect, in order to be considered satisfactory for them. For example, if a client rates his life at a "2" before therapy, now he rates himself at a "5", and he would like to be at a "7" to be more satisfied, the therapist would ask "What things you could do in the next few weeks to bring it up to a "6 or 6.5?" An useful homework assignment would be: "Starting now and, the next time we meet, notice and keep track of all the things you are doing that would be a "6 or 6.5".

Narrative therapy is based upon the concept of social constructionism (Freedman & Combs, 1996). Narrative therapy allows the client to have a voice to create his or her own meaning through dialogue. Allowing the client the freedom to tell his or her own life narrative and rewrite his or her own story is powerful for the client to increase his or her own understanding and for the therapist to experience. Narrative therapy is conducted at the client's pace and not the therapist's. In addition to that, the client is also given the

time to reconstruct his or her own life narratives by starting a journey toward growth. Narrative therapy interventions included journaling and meaning-making. For example, a client, who enjoys writing, could journal and incorporate writing with understanding how he or she can find new meanings in life. The client's presenting problems can be re-discovered through writing. Using this type of strategy can start the client's new life journey towards growth. Narrative therapy is very useful in deciphering the meaning of nodal events in a family, such as letting the children know about their mother's diagnosis of breast cancer. Questions about the meaning a client creates about significant events in his or her life, such as his or her mother's cancer, can be a major starting point for a client. By allowing the client to address questions about meaning, he or she will re-discover his or her personal qualities, relationship characteristics, goals, beliefs, values, and meanings from how others fit into their story (Freedman & Combs, 1996). Asking questions such as, "what does it mean to you have illness as a part of your life now?" Such questions help the client make meaning in whatever makes sense to the client. Narrative approaches are useful for adolescents with mothers, who have been diagnosed with cancer, because of the power of rewriting his or her life narrative and finding power in his or her realities. The approach fits nicely when working with clients who are making meaning of their chronic illness and writing their personal stories about their personal competence and growth through this therapeutic process.

Both of those models fit nicely with social constructionism because they both allow clients to construct their own interpretations or realities of their experiences surrounding their mother's illness. Ideally, when providing therapy to clients, I would like to implement more open communication and to offer the adolescents opportunities to

create meaning of the changes within their families, which includes addressing the themes of role change and responsibilities, emotions and behaviors, perceptions of and knowledge of parental cancer, and ways of coping.

As I stated in my introduction, my question is how the mother addresses her illness with her adolescent and what can we do, as professionals, when working with this specific type of client. How does an African-American mother, who is naturally, as defined by her culture, to be the caregiver in the family, deal with that role change and how does it affect the family functioning and especially the adolescent's ability to cope? I feel that an African-American mother and her adolescent's experience will be different than a Caucasian American mother and her adolescent's experience. This is a vital step in understanding more about the role of race, culture, and ethnicity within the family responses to parental breast cancer.

Limited research has been gathered on the breast cancer experience of African-American women as well as African-American adolescents (Bourjolly, 1999; Davey et al., 2005; Farmer & Smith, 2002; Wilmoth & Sanders, 2001). Findings reported that African-American women, coping with breast cancer, expressed that prayer and family support played a vital role during their illness (Ashwing-Giwa, 1999; Bourjolly, 1999; Gates, Lackey, & Brown, 2001). Wilmoth and Sanders indicated that African American women relied more on their families and friends for support but they were not always supported in the fashion they needed. Lackey & Brown found, through interviews with 13 African-American women recently diagnosed with cancer, that women explained that their spirituality that consist of relying on God throughout their breast cancer experience (2001). It was suggested that health care professionals should become more aware and

culturally sensitive with understanding the experience of these women and their families and assess when those social supports are not present for these women. Still little is known about the differences of how African-American women cope with breast cancer, when compared with Caucasian women (Bourjolly & Hirschman, 2001). Therefore, it is important to understand more about the mother's experience, as well as the adolescents' experience, so we can become more understanding of coping styles and promote more culturally sensitive and culturally relevant ways of working with this specific population.

Rolland (2003) stated that, "cultural norms vary in such areas as the definition of the appropriate "sick role" for the patient; the kind and degree of openness about the disease; who should be included in the illness caregiving system(e.g., extended family, friends, professionals); who is the primary caretaker(almost always wife/mother/daughter/daughter-in-law), and the kind of rituals viewed as normative at different stages of an illness (e.g., hospital bedside vigils, healing, and funeral rituals). This is especially true for minority groups (e.g., African American, Asian, and Hispanic)" p.483

The gap in the literature is examining more about illness and how families, especially adolescents, of different backgrounds handle it differently. Through the review of literature, I have addressed common themes and how they fit with research in the area of parental illness and adolescents. In addition to that, I have examined theory by examining studies starting with systems theory, then moving towards family life developmental theory, and finally moving in a direction of a family illness belief model. The next step in the report is the address the clinical issues those families experience as they experience changes in role, family functioning, and ability to cope. How theory and

research can provide some closure to that gap in literature of addressing these issues with African-American families and adolescents.

CHAPTER 4 - Clinical Issues When Working with African-American Families

The quote by Rolland, in the previous chapter, is an excellent example of specific clinical issues clinicians have to consider when working with families. Working with any families requires us to view them as unique and as opportunity for us to learn more about their family beliefs, culture, and their functioning. When working with African-American families, it is very important that we understand their views of therapy. Many African Americans can view therapy as humiliation, powerlessness, and even defeat. McGoldrick, Giordano, and Pearce (1996) suggested that families often need to address the purpose of mental health services and discuss and dispel any myths they may have about therapy. When working with African-American families, we need to be aware that they are more likely response to therapy that is time-focused and utilizes problem-solving approaches and child-focused therapy offered by an active and directive type of therapist. In addition to that, therapists, working with medical therapy cases, should also understand the meaning making of illness within the family. Rolland (1999) suggested that families, dealing with parental illness, understand meanings of health problems but also discuss them in relationship to their family caregiving system. It is important to recognize the changes in the demands placed on them by the parental illness but also the developmental issues of the family and each member of the system. Addressing the normative developmental issues of the adolescent and how those changes might differ because of parental illness is also another clinical issue to address with families.

Life cycle issues

Life cycles are commonly referred to by researchers as the stages of development through which a family proceeds through the course of its life. The family may undergo a process of birth, growth, shrinkage, or even death (White & Klein, 2002). When working with families' dealing with parental illness, life cycle issues are quite apparent. The timing of onset of mother's illness can affect not only the mother but the entire family. All of the life cycles of every family member disrupted to some extent. Developmental transitions between life cycle stages become complicated. Illness is a time where developmental transitions are important to discuss with family members. It is important to understand if there will be any changes within the life cycle stages of any individuals in the family.

Drawing from Duvall's model (1957), Carter and McGoldrick (1989) developed stages of the family life cycle, which includes six different life cycle stages. The family life cycle stage begins with leaving home and being single young adults and ends with families in later life. I choose to emphasize the emotional process of families who are at the stage of having adolescents. Carter and McGoldrick reported that families with adolescents have to deal with increasing their flexibility during this transition from childhood to adolescence or adolescence to adulthood. Family boundaries, which are sensitive to the children's independence, should be readjusted at this time in the cycle. Developmentally, those changes lead to a shift in parent-child relationships and permit the adolescents more movement in and out of the family system. The couple begins to refocus on their middle-life marital issues, as well as middle-career issues. Lastly, the family shifts in joining towards caring for the parents' parents. Families regularly move through these stages as a typical life cycle. However, having a family dealing with this

cycle, while also having parental illness as part of a life cycle issue makes this task far more difficult and very complicated. The following case illustrates the point:

A couple is in their mid-forties and has two teenage children, a daughter and a son. The mother was diagnosed with breast cancer two years ago and has undergone chemotherapy, as well as radiation treatments. Because of a recent reoccurrence, the mother is unable to work. The oldest daughter, aged 17, has dreams of attending college this semester but feels guilty for abandoning mom in her time of need. Her brother, aged 16, has a few more years remaining in high school but feels that it is necessary for him to pick up a part-time job because of the family financial hardship. Parents have always felt that the children should only dedicate their time to their studies and not work during high school. Parents are having a difficult time with life cycle transition of parent-child and accepting their adolescents' moves towards early adulthood and making adult decisions. It can be difficult for the parents to let their children differentiate from the family. At a time when the mother must focus on her illness and getting well and the father must give extra attention to his wife, both parents feel neglectful of their parental responsibilities, as their children rush to adulthood, in part, because of the mother's breast cancer. It seems to accelerate the beginning of the empty nest for the parents. The son starts working and his grades plummet. He begins to stay out late in order to avoid mom's illness and starts drinking with friends. His drinking lets him avoid responsibility in coping with mom's illness and his decline in school. The family is currently experiencing many transitional changes as a normal family, with the daughter's starting college soon. In addition they also have to cope with the son's behavioral issues.

This case illustrates life cycle issues, including the illness transition, the adolescents' transitions to early adulthood, and the issue of daughter's launching into to young adulthood. The son is not expressing her fears of losing his mother and the daughter is reconsidering her dream of beginning college in order to spend time with mother. The daughter feels the need to be there to care for her mom and does not want her mom to feel abandoned, because dad is working longer hours and the son is avoiding spending time with the mom. Father and mother are having conflict, due to difficulties with the shift in parenting, as well marital issues during another life transition of mid-marital and mid-career choices. The mom has always had the role of handling more of the household, as well as the disciplinary, responsibilities but her health has not permitted her to do as much. Because of those changes, the couple has difficulties communicating with one another and the children begin to notice tension between their parents.

Family communication

Rolland (1999) stated that the foundation of a family's adaptation is based upon how a couple communicates during illness. He reports "to master the challenges of chronic conditions, couples must meet the complexities of maintaining a viable, balanced mutual relationship with dynamics of patient-caretaker; to cope with the uncertainties of planning and achieving normative life goals in the face of threatened loss" (p. 255). The couple has to establish a system that works well for them in order to understand each person's role. Communicating openly about those changes in their roles and coping with those changes are vital in maintaining a health relationship and understanding in the couple dyad. The case mentioned earlier addressed the couple's having issues with parenting as well as coping with the recent financial hardship of paying for the mother's

medical bills with just the husband's income. The couple is dealing with many issues at this time and they can easily have conflict, due to not communicating effectively with one another, regarding issues such the illness/caregiving, their marital relationship, and ,in this case, their children. The husband and wife might be dealing with the uncertainty of loss because of her cancer's reoccurring. Of course, the children are aware of this reoccurrence and are dealing with the possible loss of their mother, as well along with typical adolescent issues. For example, the adolescent might be dealing with school and relationship issues of their own, as well as dealing the actual transition to adulthood. However, they might not have as much time to deal with those self issues because of new responsibilities they have in order to take care of their mom. The family is dealing with a lot, including uncertainty, possible loss, transition, and financial strain. All of these are crucial issues that must be addressed within the family. However, the cancer diagnosis significantly added to the burden of stress to this family who is already in a stressful period of time- adolescence. Such issues must be discussed with clear and coherent communication for a family under tremendous stress, who has adolescents trying to differentiate from their family of origin. This is a very difficult task to accomplish. A family meeting might be helpful for family members to openly communicate their concerns with one another and to encourage one another to discuss what has been difficult for them and how they can support each another during this time.

Parent-child relationship

Specifically, the parents might be having a difficult time communicating those noted clinical issues above with their adolescents. The parents, at this time, might be dealing with feelings of depletion emotionally, physically, and financially. Discussing

mom's illness with the children might be more of a strain. Although all these issues are present, it is important that the family remembers open up communication and share things about the illness and seriousness of the mother's medical condition. It is important that parents assure their children that they will be secure and cared for, even though the mother is ill, and to encourage communication about their mother's illness, so the children are involved and support one another during this challenging time. The case illustration pointed out that the son was having a very difficult time dealing with his mother's illness and was avoiding his mother's illness by using alcohol to deal with these emotions. In addition to that, the daughter was reconsidering her dream of going to college and staying home to care for her mother. Both of the adolescents in this case had not openly communicated with their parents about their own emotions and possible loss of their mother. Adolescents could be encouraged to communicate with one another to help them relate each other's emotional state. Support groups, friends, or even school counselor may be good resources that the adolescents could cultivate during this challenging time.

Role changes

A challenging issue for parents is maintaining functional roles as caregivers, as well as parents, when the ill parent is dependent upon and needs to be cared for by partner or, in some cases, by their own children. In the case illustration, the daughter planned to not attend college because she wanted to care for and spend time with her ill mother. The father was not as available to talk things over with her, because he had taken a part-time job to makeup for the loss of his wife's income. His caregiving duties to his daughter were limited. The son was also working part-time to help father with any

finances and was also avoiding spending time at home and seeing his mother ill. This family suffered from several role changes and everyone began to move into different roles, in order to cope with mom's cancer. It is important to clarify the degree and time of what is need as a caregiver (Rolland, 1999). Clinicians play an important role here to offer parents' limits within establishing boundaries of their new roles. Families have to define what would be needed in this time of crisis, as well as, what is normal for them in the area of caregiving responsibilities. Parenting/childrearing responsibilities of the parents also have to be addressed between the healthy and ill parent. Therapists can explore more about roles, prior to the illness, and changes in roles at this point in the family. In addition to that, the therapist could inquire about family members' being caught in the middle of an emotional system. Murray Bowen (1971) refers to this as "triangulation." Triangulation occurs when two people are not able to discuss an issue because each feels anxiety about the topic. They lower their anxiety by placing a third person between them and communicate through that third person, thus, lowering their own anxiety at the expense of that third party. For example, the son might feel triangulated with his mom and dad by feeling caught between both parents, regarding the issue of what caregiving responsibilities should belong to whom in the home. The son might feel like he is caught in the middle of both parents because of their differing views. Levels of differentiation might become problematic with the adolescents when parents notice they are not as involved with the family and their parents want and appear to separate from the family, forming outside relationships. If the family would have established mutually agreed upon boundaries with one another, things could have been different for them. Role transitions could have been discussed openly and negotiated

among family members. Triangulations could have been avoided with more direct communication and mutually agreed upon boundaries because anxiety would have been lowered. Issues of differentiation could have been processed without having family members feel enmeshed or cutoff. Adolescents should be comfortable with assuming their new roles and responsibilities. It is necessary for the family to encourage a balance and reason with the new roles within the family.

CHAPTER 5 - Therapy with African-American Clientele

Therapist needs to join well with family and have trust among the family members (McGoldrick & Gerson, 1985). It is important to as therapist to help the family feel comfortable and welcomed as part of joining and creating a therapeutic relationship. Therapy might not have a positive meaning for the family and emphasizing that therapy is a safe environment is a crucial first step in therapy. Joining with the family offers acceptance of the family, as well as respect for their way of doing things. An effective way to gather information about roles and relationships of different families is constructing a genogram. This is a diagram of family through two to three generations. It is also important that the family understand that the purpose of genograms is to give them and the therapist a complete picture of the family and that the information is not gathered to “pry” and to expose family “secrets.” For example, illegitimate births, parents’ martial status, deaths due to illness such as AIDS, domestic violence, substance abuse, or even incarcerated members of the family, all might become disclosed when gathering genogram information. Some of these events and relationships may be a source of embarrassment to the family. The therapist needs to reassure the family that the genogram will expose patterns of past behavior which may help the family to cope with its present difficulties, that of the mother in the family being diagnosed with cancer.

Working with African Americans, therapists must be willing to expand the therapist’s “definition of family” (Jurich & Johnson, 1999). Extended kinships systems are important parts of African-American families and an understanding of that in family functioning (McGoldrick, Giordano, & Pearce, 1996) Family therapists should also

understand the possible differences in the structures of African-American families. What might seem unusual to us might be a functional system for families (McGoldrick, Giordano, & Pearce, 1996). It is important for family therapists to understand ask about who lives with the family, what family members live elsewhere, and who provides support if needed in the family. Family support is a vital piece in understanding more about the family system and who will or will not be actively participating in the therapy process. Typically, couples who seek therapy usually have concerns with their children. The children may be displaying problems in the home or school because of the couple's relationship and so the parents bring children to therapy, rather than giving themselves as the reason for seeking therapy. This is quite common in therapy when marital issues are present and the couple prefers to see the children as the presenting problem. Women are the ones who most often initiate starting therapy. McGoldrick, Giordano, and Pearce explained that women are often concerned with relationships and hold the strong tradition of remaining together and working on issues as a couple for the sake of children. It was also noted that women had a difficult time because, although women often expressed dissatisfaction in the relationship, they were also resistant to change. Women struggle with the challenge of avoiding putting a burden of their partners with their concerns and joining the societal chorus of "beating their men further down" (McGoldrick, Garcia-Preto, Hines, & Lee, 1989). Therefore, therapists should explore a wider range of issues, in addition to the presenting problem, with the clients to gain a better understanding of that societal view and offer clients the opportunity to explain what might be most helpful for them.

Parent-child systems can also be different for African-American families. Sometimes children within the family are in “parentified- child roles”. A child is typically “parentified” when parents work or they have several siblings (McGoldrick, Giordano, & Pearce, 1996). In this particular role, children might be pushed to assume more parental type responsibilities for their siblings or children might just adopt these responsibilities without their parents direct consent. There is simply more work than mom alone or mom and dad together can handle. This change might create conflict between the parents and the children. For example, a child might be in a position to assume responsibilities of guidance, control, and decision-making that he is not developmentally prepared to do. Either the job will be done poorly or the child will suffer developmentally. This might become a huge conflict with parents and they will struggle with developing healthy family boundaries and structures, not only for the children but for the family as a whole. When this type of parentified-child system becomes a problem for families, the therapist might have to work on ways to re-establish the child’s role in the family and to eliminate any stressors that have become a burden for the child because he or she tried to take on the adult role.

Working with African-American families can be a unique experience for therapists. Summarizing what I have learned from the family therapy literature, therapists need to of join well with clients and be direct, open, genuine and empathic with this specific population. Those particular qualities are important because African Americans seem to connect well with having that openness, honesty, and trust with therapist because they are similar to qualities of having the support of the community or family in the African-American culture African-American clients often make decisions about

continuing therapy sessions with therapist, based upon his interpersonal evaluation of the therapist (Sue & Sue, 2003). Authors stated that working with African-American clients can be much broader than working with Caucasian clients. Therapist may have to be more directive, more resourceful, and provide more educational functions. Being directive, resourceful, and providing more education are important for all clients, but especially African Americans, because of the lack of availability of resources and lack of encouragement to utilize them. African-American families need immediate results which are linked to pragmatic courses of action in order to continue to work in therapy and place their hope in the therapeutic process. It is beneficial, during early sessions, to understand the families' background and to understand their thoughts and feelings about therapy. It is important to determine their viewpoints to understand their thoughts about problems, solutions, and growth towards change. In addition to that, in establishing a clear egalitarian relationship with minority clients the therapist provided a partnership with the client. Most African Americans tend to work best with establishing a personal commonality with the therapist (Sue & Sue, 2003). This is why it is so important to understand their positions and their sense of understanding about their problems. It is important to guide them through the process of achieving that understanding in session through joining and asking clarifying questions. It also offers African Americans that sense of unity and family commitment that enables them to support and help one another. Therapists should assess for positive strengths with clients, such as supportive systems, such as family, friends, community resources, and, of course, church. Sue and Sue (2003) also noted that the therapist should help clients define and goals and help them construct appropriate ways of attaining those goals. It is necessary to assess ways in which the

client, family members, and friends handle problems effectively when achieving their client goals. Pointing out those successful coping strategies is important, so clients can recognize their strengths and assure themselves that they have the necessary tools for accomplishing their goals. Once those goals are clear, Sue & Sue suggest that the therapist use more a problem-solving, solution, and time-focused approach with African-American clients (2003). Using these approaches with African-American client builds upon their strengths and helps them recognize the positive changes and benefits of investing in therapy.

Working with African-American Adolescents in Therapy

Adolescent youth in African-American communities can be present several different types of life issues in therapy. According to Frame and Williams (1996), specific strategies are suggested to use when working with Black youth. The first strategy is the use of metaphor, which is based upon African tradition of storytelling. Storytelling is a great intervention when working with adolescents because it gives them a chance to share their point of view. From a therapeutic standpoint, storytelling is part of narrative therapy and it can be a helpful in separating self from the story to become more comfortable and use more creative mediums, such as narratives and metaphors. Historically, storytelling for African Americans has always been important in order to share with other family members their struggles with slavery and how they have overcome them. Storytelling in therapy builds upon this oral tradition and feels comfortable as a means of communication in African-American families.

Next, joining with the adolescent in a way that gains an understanding and appreciation of their interests and what appeals to them is crucial. Understanding

adolescents is very important because, the therapist is showing interest in him or her and is attempting to understand things on their level. An adolescent wants to be understood and heard by adults but often feels ignored by those same adults. Building this type of relationship is vital in establishing a therapeutic relationship. For example, there might a particular song that the adolescent relates to and it would great to have he or she explore lyrics with therapist to gain more insight about the client's feelings and thoughts about presenting issues. Another strategy may be to learn more about the adolescent's family and the role he or she plays in family, as well as other support systems. This type of information gathering is important to capture a glimpse of the adolescent's position in the family. It is crucial for the therapist to get a true picture of the adolescent and not assume stereotypical behavior from the adolescent clients. In this way the African-American adolescent will feel respected and affirmed. Paster recommended discussing expectations of the usefulness of being in therapy (1985). Adolescent clients may not understand the nature of therapy and why they should participate. Secondly, Paster emphasized the importance the duration of therapy and timeline of attaining goals. Therapists are suggested to set limits, such as setting boundaries early on with adolescent clients. Boundary setting is important because it establishes respect of one another in therapy as well as other settings. It also might be that boundaries have never been established with adolescents and establishing those could be very helpful to the success of therapy. Overall, when working with adolescents it is important to be clear with them and to offer them a therapeutic relationship that offers trust and understanding of the client. It is very important that therapists offer those things to African-American adolescents because of possible past experiences when trust and understanding were not offered, especially by

authority figures. African-American youth can appreciate when an adult respects them and allows them to be heard and promotes positive feelings about themselves and their sense of culture as an African-American youth.

Working with African-American Adolescents Dealing with Parental Breast Cancer

The limited family literature has addressed the clinical issues of working with African-American adolescents who are dealing with their mother's breast cancer. From the research that exists, the clinicians are advised to become prepared to work with role changes and family functioning with this specific population. In addition to what was stated earlier, therapists have to build a trusting therapeutic bond when working with African-American families and their adolescents. Not only is a bonding important to clients but therapists must gain an understanding of the unique family structure and their relationships. Gathering information around family illness beliefs is also an essential part of starting therapy with this population. Genograms can be helpful in understanding any patterns or themes in families, regarding types of illness and how illness was communicated among the family members. Because the family might be dealing with various types of issues, just by having an adolescent in the family, it is of importance to have a clear understanding of the families' purpose for seeking therapy, even though there is an obvious problem of parental illness.

The focus here is to understand from family literature of working with African-American families and then working with African-American adolescents, specifically, we need to understand what to apply from those dynamics of working with African-American adolescents' dealing with their mother's illness. As I stated above, there are necessary aspects to consider when working with this specific minority group.

Additionally, other family dynamics have to be addressed because of parental illness. Let's apply what we had discovered from the family literature and expand upon it, addressing the clinical issues of role functioning and changes. For the case example I described earlier, the mother was diagnosed with cancer a few years ago and recently was told that there is a reoccurrence. The family dealt with the mother's first diagnosis fairly well, with their children beginning their adolescent years, and family member supported one another through the course of the mother's illness. Now, the reoccurrence has come at a time when the family is dealing with some severe general life transitions, with daughter's graduating and beginning college as well as the brother's finishing up high school very soon. In addition, there is the uncertainty of treatments not being completely successful for the mother in the past and the possibility of it not being successful again this time. Therefore, each family member has lost some of the hope that helped carry him or her through mom's initial struggle with cancer. The father has to deal with financial hardship because of the mother's treatment options, her loss of income, and the family's preparing for their daughter's tuition and board for college in a few months. The family is suffering from several clinical issues that have not been addressed with one another. They are dealing with the son's having a most difficult time, failing grades in school as well as getting involved with alcohol as a way of coping with everything. As you can see, the family is dealing with both individual and family issues that should be addressed in therapy.

Working with family's dealing with issues such as described in the case example requires therapy that addressing not only the illness, but the role functioning and changes within the system. The family literature is quite limited with providing specific treatment

approaches when working with African-American families. Rolland (1999) addressed, in his several of his articles and books, the fact that therapists should create uniqueness for specific types of cases. In that uniqueness, it is important to address general issues, such as life cycle issues, family communication, and role changes, as they would when working with any family or adolescent in general. However, there are not any specific articles to address specific clinical issues when working with African-American adolescents. I feel that different aspects of the family literature have addressed how to work with families in general and also with adolescents separately. By combining information from both of those dynamics, I believe the therapist has a greater idea of what would be basic strategies to addressing presenting issues which the family brought into therapy. African-American families value family and should have a great appreciation of working with a marriage and family therapist's perspective of working towards ways of keeping the family together.

CHAPTER 6 - Course of Therapy

Throughout this paper, we have learned more about the African-American family's and the adolescent's experience of having a mother with breast cancer. Now, I will focus on applying what we have learned when working with African-American families and adolescents. Let us walk through the course of therapy, using the case illustration used in the previous chapter.

Let us examine what the course of therapy would look like for the family dealing with mother's reoccurrence of breast cancer. The course of therapy begins three months after the mother's reoccurrence. At this point, the daughter has graduated from high school and preparing for her move to college. The son is still distant from the family and has moved to a family friend's house. The father has been working long hours at his day job, as well as part time on the weekends. The mother and daughter have been spending more of their time together at home. The mother and daughter have decided to come to family therapy to address adjustment issues. The son and father were asked by the mother and sister to attend but were not open to therapy at this time.

During the first few sessions, therapist spent time joining with the mother and daughter. Joining is the process in which the therapist and the clients get to know other another and become more comfortable with one another. Joining with the mother-daughter dyad, who are dealing with the mother's reoccurrence, is crucial, since the mother and daughter are dealing with a lot of uncertainty, as well as not having the support of the father and son. It is very important that the therapist allow the daughter and mother express their feelings regarding the illness. At this point, the therapist is encouraging the mother, as well as daughter, to invite the father and son to therapy. The

son attended a third session with the mom and daughter. The therapist offered the son the same warmth and respect that she offered the mom and the daughter during the first few joining sessions. The son was more resistant to offering his feelings in session but was attentive and open to being there for his mom and sister.

Following the first three sessions of joining and the family's offering their storytelling, the therapist thought it would be a good time to establish goals but met individually with the adolescents to allow them to address any concerns without their ill mom's presence. The son and daughter expressed concern for the parents, especially their mom. The therapist used a narrative therapy intervention to encourage the siblings to think of a medium, such as writing, art, or music, to construct their meaning of the experience with mom's first diagnosis and now the reoccurrence. The therapist felt this exercise was important because it allowed the clients the freedom to tell their life narratives of their mom's illness. It allowed the adolescents to connect with therapist by sharing apart of themselves. This is important, in African-American traditions, to have a safe, respectful, and open environment, which allowed them to have a sense of connection with someone who is listening and trying to understand their story.

The next session consisted of reading and exploring the letters that the siblings wrote about their experience of having a mom who is ill and how it has been difficult for them to talk about it. The therapist listened a lot during this session and asked meaning making questions in order for the clients to express their thoughts clearly and to gain more understanding of their story and experience. For example, "What does it mean to you to have a mom with breast cancer?" I also incorporated a solution-focused intervention by using the miracle question. A good miracle question would be to ask the

son and the daughter, “Suppose the two of you were to go to bed tonight and a miracle occurred, when you awake in the morning, miracle has occurred and your problem was solved. What would be different? How would the two of you know?” Therapist asked, in detail, what would be different so that they could recognize if they have overlooked those things or if they could make small behavioral changes in order to see those changes. For example, the daughter wanted to spend time outside the home with friends and have her brother more involved in spending time with mom. The son wanted to spend time with mom but did not want to be as involved as the sister in caring for mom, especially after she started college. He expressed the fear that he would “lose his life” if he was expected to be the full-time caretaker. The siblings had a difference in their miracles but compromised by agreeing upon a time schedule that would work for both of them.

The next session, which was the fourth session, the therapist invited the siblings and the mom for a family session. The mom was asked the miracle question and stated she would like her children to be more involved in things they love and not to worry about her as much. The family was asked to come up with goals for therapy and how they saw themselves achieving those goals. It is important that the therapist should help the clients define goals and help them construct appropriate ways of attaining those goals. The next step was to work on the treatment plan and ways to achieve their goals.

In future sessions, I feel it is important to check in with the family and to ask about the progress of achieving their goals, as well as any updates with mom’s illness. Scaling questions will also be important throughout this course of therapy. The siblings and mom were asked where they would rate themselves in order to feel more satisfied with their goals. The final scaling questions provide the clients with the opportunity to

recognize that things do not have to be perfect to be considered satisfactory for them. For example, if a client rates his life at a “2” before therapy and now he is at a “5”, and he would like to be at a “7” to be more satisfied, therapist would ask “What things you could do in the next few weeks to bring it up to a “6 or 6.5?” An useful homework assignment would be: “Starting now and the next time we meet, notice and keep track of all the things you are doing that would be a “6 or 6.5”.

It is important to use scaling with the family in order to understand more about each other and to create dialogue among family members in session. Exceptions are also important as therapy progresses for the family. Drawing upon those exceptions, is a pointing out their family strengths in one another and giving them hope in envisioning things differently for them, even though, they are dealing with the mother’s illness. It allows them to focus on more positive aspects of the things they are doing well as a family. Consequently, this improves overall functioning as a family.

Incorporating some structural interventions can also be helpful with narrative and solution-focused therapy. For example, the therapist might want to assess role changes which are necessitated by working on their goals. Using a family sculpting exercise can be very helpful in the family hearing and seeing a visual and their progression in their roles in the family. A family member is asked to physically position the family, including himself or herself, to symbolize the typical roles or positions which each family member takes in a specified situation. Once positioned, each family member is questioned as to how he or she is feeling and how they understand the role into which he or she was sculpted. Establishing those connections with making progress and pointing out changes with the family can be an eye-opening intervention in itself.

As the family progressed through therapy goals have been achieved. Clients identified issues, such as their family communication, mom's illness, and the adolescents' roles through the use of the SFT and narrative approaches, such as the storytelling exercises, scaling questions, miracle questions, and family strengths through exceptions. The family recognized significant changes in their relationships and functioning as a family, through the use of the therapist's interventions. Because measurable goals were established and the family has noticed growth with one another in communicating better, and spending time enjoying things outside of the home. In addition, mom's treatment has been going well. The family decided that they would meet once monthly with therapist. The therapist did offer to contact therapist if additional sessions were needed during the month.

At the last session, before starting monthly sessions, the therapist shared the progress that they saw in each other, as well as things that have helped their relationships within their family. The family understands that their goals are not fully achieved but continues to work on them. The therapist feels confident that the family is in a good place and that monthly sessions will continue to be beneficial in their growth.

I think I have addressed basic issues that might help us to understand that the roles of race, culture, and ethnicity play a part in the family process and moving towards presenting projects that address those unique experiences, when working with such as specific population.

Summary of Treatment Approach

As a therapist, I feel my role is to have a connection with my clients to assist them with a personal journey towards growth. I think that, when you are connecting with clients who are dealing with such clinical issues, you are not only contributing to their growth but, as a therapist, you are growing. Because of my interest in family therapy within the medical setting, I am drawn to narrative therapy, solution-focused therapy, and structural therapy. I feel that narrative therapy uses the concept of the client's reality and what it means to consider that particular reality. The use of a narrative allows the client the freedom to tell their life narratives, that storytelling important in African-American traditions, and to rewrite their own stories. It also allows the clients to experience the power of their story and to move toward growth at their own pace. In addition to that, it allows a client to understand how he or she can find new meaning in life and rewrite their life journey, making meaning of with chronic illness in the family. Through writing of personal stories, the client or clients will discover more about their personal competence and growth through this therapeutic process.

Narrative therapy, in way, is like having basic watercolors for your canvas and using those basic colors to create a variety for different colors and items in your landscape. It is quite similar in the specific population I have discussed in this report, which consists of diversity among age, socioeconomic status, race, gender, ethnicity, and geographical locations. As a therapist, I look forward to "presenting problems" that might range from typical mental health concerns to problems with coping with acute and chronic medical illness with minority families.

From a narrative approach, I would use interventions that would encourage the client to create and attribute meaning to symbolize their experiences. By making

meaning, the client could possibly move towards finding words to represent a positive aspect of coping or surviving their experience. Another way of constructing meaning might be used to use different forms or mediums. For instance, I could encourage clients to choose a medium such as writing, speaking, art, and music to construct their own meaning, regarding their experience of parental cancer. This supports the earlier suggestion by Sue and Sue (2003), that is applicable when working with adolescents and using ways to join and understand more about the adolescent's emotions and experiences of having a mother with cancer. An adolescent might find these creative interventions helpful by creating a CD of songs that have a particular meaning, a collage of pictures, photograph scene, collection of poems or short stories, making an audiotape of their thoughts, drawing, painting, or journal writing.

Structural therapy would also fit nicely with the treatment model of working with families who are dealing with parental illness. Addressing any changes in roles within family system, especially with the adolescent, will be vital when treating the system. Assessing for role changes because the mother is suffering from breast cancer is important to discuss. The actual roles of the caregiver or caregivers in the family are just as important as the other roles in the family. How that specific role change might affect the mother, the husband, the adolescent and other family members is crucial. How functioning has changed will be very important. Family sculpting might be a great intervention in understanding the structural changes within the family to identify what the family feels and how they would like to see differently. Adolescent make excellent sculptors because of their insight and natural relish in manipulating their parents. Also, family strength exercises could be used to understand what role each member plays and

how that specific role strengthens the family. For example, the family could use family role cards in session and identify with one another both their perceived roles and expected roles. Through this activity, the family can focus on positive roles that might be overlooked by each other.

Solution-focused therapy is another approach I feel will be viable with clients dealing with clinical issues. As stated earlier, African-American families work well with solution focused and time focused type approaches during therapy. Solution focused approaches could fit nicely, once the adolescent and family have clearly defined their goals in therapy and are working toward some changes in the presenting problems they are facing within the system. Asking clients, dealing with an illness, about a miracle's occurring for them too early in the therapeutic relationship can be harmful to client. For example, asking a miracle question with a client, who cannot make a clear distinction of the miracle's not happening, may create a false dream of mom's regaining her health completely. When used appropriately, I envision using solution therapy with clients to ask scaling and miracle questions to monitor growth in making small steps towards change. I will also use exceptions to highlight their strengths and look at things for a more positive outlook. I envision using scaling questions to understand more about diagnosis and treatment since illness, as well as understanding how clients perceive things differently within their family. Miracle and scaling questions would not be used in a typical fashion because the therapist would not be seeking solutions to a specific problem but instead would focus on how the family can envision things differently with the successful completion of therapy. It is important that the clients have a clear distinction that the miracle, such as regaining health, may not happen. The therapist does

not want to lead the client in having the false hopes of believing that the miracle results in no longer having an illness. The goal here is to challenge the client to focus on more positive ways of how he or she would function differently.

As far as protocol with this specific population, I feel the approaches I have described above are flexible. I am willing to adjust with client and I know people vary, even though I am examining a specific population. Some clients might be open to some approaches of therapy and some clients might not. I think the key for a therapist is learning how to “switch gears” with approaches by observing clients, as well as requesting feedback from clients. Personally, for me, conceptualizing cases, has been helpful in the understanding the process.

Conclusion

Working with families dealing with their mom’s breast cancer can be a challenging process for clients. The journey can be life-challenging for the entire family. Throughout this paper, I hope I have offered you, as the reader, a better understanding of the African American family and the adolescent’s experience of the mom’s having breast cancer. I hope that I have given richness to the topic in the hope that other researchers will explore more about the topic as well. Future research would help to develop interventions for the adolescents and their families. As well as addressing interventions with minority groups. I would recommend that marriage and family therapists and researchers continue to study families’ dealing with parental illness and enhance more coping strategies for adolescents and their families who are coping with the diagnosis and treatment of the mom’s breast cancer.

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